Leveling the Field

REPORT OF THE NIH TASK FORCE ON DISABILITY

NATIONAL INSTITUTES OF HEALTH
BETHESDA, MD

OCTOBER 2001

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THE NIH TASK FORCE ON DISABILITY

In September 2000, the President issued Executive Order 13163 mandating the Federal Government to accelerate recruitment of qualified applicants with disabilities. A companion Executive Order was also issued that charged every Federal agency to implement and document a reasonable accommodation program. In response, Dr. Yvonne Maddox, Acting Deputy Director, National Institutes of Health, convened a Task Force on Disability to review the current status of disability efforts at NIH, identify challenges and barriers to progress, and develop recommendations for improvement. The Task Force consisted of six subcommittees that worked together to develop this report.

TASK FORCE MEMBERSHIP

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Members:
Duane Bonds (NHLBI)
Anthony Clifford (ORS)
Carlton Coleman (OEO)
Elizabeth Dean-Clower (NCI)
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David Kerr (NIDCD)
Michael Lang (CSR)
Dona R. Lenkin (CIT)
Pedro Morales (OD/OEO)
Beverly Mushinsky (NHGRI)
Carol Sheredos (NICHD)
Bob Waldman (OD)
Michael Weinrich (NICHD)

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Members:
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Jerry Garmany (CC, EEO)
Katina Jocktane (OD/MI)
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Dan Young (CIT)

Ex-Officio:
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Leslie Barden (CIT)
Gary Morin (OD/OEO)
Marcella Haynes (OD/OEO)

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Subcommittee Chair:
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Patrick Weld (OD/PMI)

Accessibility

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Kristy A. Long (ORS)

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Subcommittee Chair:
Donald Poppke (NLM)

Members:
Felicia Brice (NEI)
Jason Donaldson (NLM)
Stephen Long (NIAAA)
Tim Tosten (ORS)
Bob Waldman (OD)

Special Thanks

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Elizabeth Dean-Clower—National Cancer Institute
Jason Donaldson—National Library of Medicine
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Anne Phillips—Center for Scientific Review

EXECUTIVE SUMMARY

Despite the historic shift in disability public policy that occurred in 1973 with the passage of Section 504 of the Rehabilitation Act, the number of employees with reported disabilities at the National Institutes of Health (NIH) is extremely low. NIH is in a position to recommit itself to providing accommodation to people with physical and mental disabilities and making all facilities accessible to and safe for them. Recently NIH has made impressive strides in improving the process for identifying and promoting accessibility for all employees. The Office of Research Services (ORS), Division of Engineering Services, in particular, has invigorated the process for improving accessibility to NIH-owned and -leased facilities since the issuance of the December 1998 NIH Diversity Council's *Report on the Task Force on Disability Awareness.* However, significant barriers remain and improvements in responding to requests for reasonable accommodation are needed.

The NIH Mission

Simply described, the NIH mission is to uncover new knowledge that will lead to better health for everyone. The discoveries made possible through NIH research help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorders to the common cold. Consistent with its goals and its stature as one of the foremost medical research centers in the world today, it is incumbent on NIH to assume a leadership role in employing, advancing, accommodating, and providing assistance for people with disabilities.

According to the U.S. Census Bureau there are more than 54 million people with disabilities in the United States and, as the population ages, the number is likely to grow. Until recently, people with disabilities constituted a largely invisible minority. That is changing as the experience becomes more common. More Americans are living longer due, in large measure, to biomedical advances made by NIH. Many also have some form of functional loss because scientific breakthroughs spared or are substantially prolonging their lives. As the Institutes and Centers (ICs) continue to redefine the boundaries of research, it is important to balance the concern for saving lives with appropriate attention to improving and optimizing the quality of life. For NIH to be any less than a model of universal access for staff and visitors alike contravenes its basic mission.

Key Task Force Recommendations

The report that follows outlines a number of steps that NIH can take now to underscore its commitment to ensuring that all staff and visitors have access to its rich stores of knowledge and opportunity. Major recommendations concern issues related to organization, financing, accessibility, policy oversight, evaluation, and support and include:

Organization

- Clearly identify NIH, not the ICs, as the "agency" responsible for establishing a set of consistent policies and uniform procedures on reasonable accommodation and facilities accessibility.
- Establish an office within the ORS to serve as the focal point for issues—excluding discrimination and affirmative action—that are related to reasonable accommodation. In essence, this office would serve

as an administrative service center for reasonable accommodation, much like ORS's highly successful management of interpreting services. ORS will continue to serve as the focal point for ensuring facilities' accessibility.

The new office should serve as a centralized locus for activities such as procedures for requesting reasonable accommodation and standards for responding to requests. The office will also disseminate appropriate information; provide specialized consultation; coordinate the activities of the Advisory Committee on Disabilities; and maintain inventories of assistive devices and other inventories. The head of the office will report to the Associate Director for Research Services, NIH.

- The Director of NIH should reinforce the fact that recruitment and placement of qualified individuals with disabilities are pivotal functions of the soon to be created centralized human resources office.
- Establish an Advisory Committee on Disability Issues that will provide advice to the Associate Director for Research Services, NIH, regarding issues under his purview, such as reasonable accommodation. To serve as the voice of the disability community on these issues, at least 50 percent of the members should be employees with a range of disabilities or supervisors of employees with disabilities. This could be a component of the existing ORS Advisory Committee, a modification of the Facilities Accessibility Advisory Committee, or a separate Advisory Committee.
- Provide, through a contract, the necessary skills to independently assess individuals with disabilities for reasonable accommodation determinations including the need for assistive technologies.

Financing

- Establish a centralized funding mechanism for the provision of reasonable accommodation, including the new office; request funding annually through the Funding Advisory Review Board (FARB) process. Because the FARB has made preliminary decisions for FY 2002 and 2003, funding for the office should be provided in the short term through use of the NIH Director's one-percent transfer authority.
- On the basis of the results of a recent assessment of NIH facilities that will be continually updated, review the adequacy of the NIH budget for correcting deficiencies. To the extent that direct Buildings and Facilities (B&F) funds are involved, NIH should request sufficient B&F resources to correct deficiencies.
- Review NIH procedures and those of the individual ICs with regard to the evacuation of staff from NIH-owned and -leased facilities during emergency situations. If necessary, request funding for any needed improvements through available emergency assistance funds.

Accessibility

- Provide universal access to all NIH-owned and -leased facilities; simultaneously address the design for new facilities while methodically removing all existing barriers.

Policy Oversight, Evaluation, Affirmative Action, and Support

- ORS, the Office of Equal Opportunity (OEO), and the ICs will support NIH in its efforts to become **the model** Federal agency for removing barriers to the hiring and full employment of individuals with disabilities. Build a proactive approach to increasing visibility of this goal through marketing and other techniques.
- OEO will revise the current NIH Policy Manual Issuance on Reasonable Accommodation (MI 2204) to encompass all members of the NIH community, including visitors and fellows, or issue a concomitant Manual Issuance that covers them.
- The new Office on Disability will compile data on the number and types of requests for reasonable accommodations, whether granted or denied, and develop and maintain relevant information such as reasons for denying requests, amount of time required to process requests, and number and type of reassignments based on reasonable accommodation.
- OEO, working with the new office and the ICs, will develop practical in-service training on reasonable accommodation and other aspects of Equal Employment Opportunity requirements to which IC managers and supervisors can subscribe. Training will include specialized sessions for supervisors on coaching and mentoring employees with cognitive and mental disabilities.
- The Office on Disability, working with appropriate partners at NIH, will ensure that NIH employees with disabilities receive technical support that is comparable in quality to that received by employees without disabilities. Train technical support staff to make assistive technologies work with standard desktop software.
- Continue to place responsibility for reviewing and adjudicating issues of *discrimination and developing an affirmative action plan* related to the provision of reasonable accommodation and facilities accessibility with OEO. In addition, OEO should retain responsibility for policy and oversight of Sections 501, 503, 504, and 508 of the Rehabilitation Act of 1973 as amended.

LEVELING THE FIELD: REPORT OF THE NIH TASK FORCE ON DISABILITY

INTRODUCTION

People with disabilities face two distinct sets of challenges in the workplace. First, they need appropriate services and equipment to perform their jobs at the highest level possible. Second, they must be able to maneuver in a workplace that is often constructed without them in mind. The design and sensory characteristics of the "built" environment affect nearly all facets of human activity, including the ability to work independently and effectively. For people with disabilities, the influence of environment is even more pronounced. It can support, limit, or preclude their participation in the services, careers, training/education, and leisure pursuits that others take for granted.

Although people with disabilities cross all racial, gender, educational, socioeconomic, and organizational lines, together they constitute the Nation's largest minority, and the only group that any person might involuntarily join at any time. According to the President's Committee on Employment of People with Disabilities, if an individual does not currently have a disability, he or she has about a 20 percent chance of becoming disabled at some point in his or her work life. The landmark Rehabilitation Act of 1973 not only acknowledged the extent of disability, but also called attention to the valuable but largely untapped employee resource represented by individuals with disabilities.

In mandating access in executive branch agencies, the Rehabilitation Act recognized that a Federal agency serves the American people better when all segments of the population are included in its workforce and when employees reflect the varied dimensions of its customer base. An agency that includes people with disabilities in its programs improves prospects of more fully accomplishing its mission. People with disabilities also add to the diversity of viewpoints required for success. Through their competent participation in the workforce, they contribute the skills and ideas essential for responding to the multiple challenges that Government confronts.

The passage of the Americans with Disabilities Act in 1990 increased awareness of accessibility issues both inside and outside Government. More recently, the President issued Executive Order 13164 aimed at strengthening the provision of reasonable accommodation in the Federal sector. The benefits realized from the full participation of all qualified applicants have further encouraged Government agencies to create worksites that are universally accessible and accommodating.

ROLE OF THE NIH TASK FORCE ON DISABILITY

Executive Order 13164 (EO 13164) charges each Federal agency to implement a reasonable accommodation program and document its progress. In keeping with the expectations expressed in EO 13164, the National Institutes of Health (NIH) is committed to becoming **the model** Federal agency with

respect to hiring and retaining people with disabilities. To realize its goal, NIH established the Task Force on Disability to:

- Review NIH-wide implementation of applicable laws and directives,
- Analyze NIH policy for its capacity to support the spirit and letter of those laws and directives,
- Identify issues affecting full implementation, and
- Recommend steps that NIH could take now to enhance its efforts to provide reasonable accommodation and promote accessibility.

The Task Force addressed five major issue areas: reasonable accommodation; facilities accessibility; recruitment, hiring, career development, and work life; information technology; and data collection. This report summarizes the findings of the Task Force and presents its recommendations for optimizing current disability efforts at NIH and improving those that may be implemented in the future.

Reasonable Accommodation

Reasonable accommodation in the legal sense encompasses several categories of accommodation for individuals with disabilities that enable them to carry out their work, such as services, equipment/assistive devices, and working conditions. Specific provisions may include accommodations such as making facilities readily accessible and usable by persons with disabilities, acquiring or modifying equipment or devices, telecommuting, job restructuring, providing part-time modified work schedules, adjusting applicant testing procedures, and providing readers and interpreters.

Policy Background

Rehabilitation Act of 1973: The concept of reasonable accommodation for employees in the executive branch of the Federal Government, including NIH, was first defined in Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), which is intended to ensure that no individual is discriminated against on the basis of disability.

Management Directive 712: The concept was reinforced in March 1983, when the government-wide Equal Employment Opportunity Commission (EEOC) issued Management Directive 712 (MD 712), which *"... prescribe[s] to Federal agencies instructions, procedures, and guidance for continuing comprehensive programs to facilitate equal employment opportunity for handicapped individuals."* MD 712 also required agencies to publicize *"procedures for prompt and efficient processing of requests for reasonable accommodation,"* assign responsibility for responding to requests, and identify separate, specific resources for providing reasonable accommodation.

MD 712 **clearly spells out a basic organizational approach to implementing reasonable accommodation.** It specifies that *"agencies should designate individuals to whom various types of requests should be forwarded and should inform managers, supervisors, and handicapped employees"* (MD 712 7c(5)).

Likewise, it articulates the **requirement for agencies to clearly establish separate and identifiable resources for providing reasonable accommodation:** *"The Executive Director has responsibility for: ensuring in coordination with the Director, Office of Program Planning and Evaluation, that EEO/AA for*

handicapped individuals is addressed by means of line items and other separately identifiable elements in agency management plans, financial plans, budget requests..." (MD 712 Appendix A, item 7b(3)).

Americans with Disabilities Act: The better-known Americans with Disabilities Act (ADA), passed in 1990, enacted disability laws for the private sector and public facilities. ADA protects people with disabilities against discrimination in employment, transportation, and building and telecommunications accessibility and closely parallels the earlier Rehabilitation Act. Although NIH is not a covered entity under the ADA, common areas in NIH-leased facilities are. As a result, both NIH employees and visitors have a right to all the protections afforded under the two pertinent disability laws.

NIH Policy Manual Issuance on Reasonable Accommodation: In 1998, NIH issued a revised Policy Manual Issuance on Reasonable Accommodation (MI 2204). This issuance was recently revised (August 2001). According to the manual, NIH policy is to provide reasonable accommodations for known physical and mental impairments of qualified individuals with disabilities who are applicants to, or employees of, NIH. The policy further states that, as necessary, NIH will provide a reasonable accommodation to ensure that an individual has the opportunity to use his or her skills, knowledge, abilities, and capacity to perform a job safely and productively. The manual also places the first line of responsibility for reasonable accommodation with the Institutes and Centers (ICs) and specifies that the policy applies to both new applicants and employees who develop a disability while employed.

Principles Underpinning Reasonable Accommodation at NIH

Members of the Task Force agreed that the following principles are the foundation for reasonable accommodation at NIH:

(1) Reasonable accommodation allows employees to perform essential functions of the job and to receive the same benefits and privileges of employment enjoyed by employees who are not disabled; reasonable accommodations ensure that individuals with disabilities have an opportunity to work under circumstances that are equitable to those of other employees.

(2) All members of the NIH community, including visiting scientists and fellows and visitors using NIH public buildings such as the Clinical Center, Natcher Building and Conference Center, National Library of Medicine, and Pepper and Shannon Buildings, are entitled to the same reasonable accommodations as those extended to NIH employees.

(3) Providing reasonable accommodation and facility accessibility should become part of the fabric of NIH support services. These issues should involve the Office of Equal Opportunity only when discrimination against a person with a disabling condition occurs.

(4) Given its budget, providing reasonable accommodation does not impose an "undue hardship" on NIH except in an extremely rare case.

(5) Providing reasonable accommodation requires problem solving on an individual basis by using policies and procedures that are consistent across NIH.

(6) The relationship between employee and supervisor is the focal point for initiating the reasonable accommodation process; in accordance with EEOC guidelines to keep the process at the lowest supervisory level possible, immediate supervisors should have a direct role in responding to requests for reasonable accommodations.

(7) Employees have a right to confidentiality with respect to reasonable accommodation. Documentation needed for the reasonable accommodation process is accessible only to those with a "need to know."

(8) Reassignment is the option of "last resort" for employees requesting reasonable accommodation and may be made only to a vacant position; NIH is not required to create new positions or to move other Federal employees from their jobs to respond to a request for reasonable accommodation.

Executive Order 13164: In July 2000, the President issued EO 13164: Establishing Procedures to Facilitate the Provision of Reasonable Accommodation. The purpose of the Order was to:

> *"...promote a model Federal workplace that provides reasonable accommodation for (1) individuals with disabilities in the application process; (2) Federal employees with disabilities to perform the essential functions of a position; and (3) Federal employees with disabilities to enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities."*

The EEOC simultaneously issued policy guidance explaining the requirements of EO 13164, as well as "Enforcement Guidance on Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act."

In response to these developments, NIH began revising MI 2204. The revised manual is intended to implement EO 13164 by establishing guidelines for facilitating provision of reasonable accommodation. Appendix A provides an overview of the legislation relevant to reasonable accommodation at NIH.

Issues Related to Reasonable Accommodation

In its review of reasonable accommodation, the Task Force analyzed policies in place at 20 ICs in June 2001 and compared them to EEOC policies and recommendations concerning reasonable accommodation. Through this process, the Task Force identified issues related to definitions and organization/structure, coverage, provision of resources, and information dissemination and followup. [NOTE: Since this review, a number of ICs have revised and refined their policies. However, the following comments remain applicable.]

Definitions and Organization/Structure

- None of the disability laws or directives define "agency." However, through its policies, it is clear that NIH has interpreted the term to mean that each IC is an agency. As a result, responsibility for ensuring reasonable accommodation is decentralized and, from the Task Force's perspective, accountability is lacking. There is little uniformity across ICs regarding timeframes for responding to requests for reasonable accommodations, standards for documenting medical information, or procedures for handling appeals. These inconsistencies have created disparities in employment outcomes for qualified individuals when compared to their nondisabled peers, regardless of job classification, years of service, skill sets, education, gender, race, and ethnicity. Without accompanying oversight and enforcement mechanisms in place, the current decentralized approach has led to inequities across ICs. Previous efforts designed to accommodate the needs of employees with disabilities reinforce the benefits of a coordinated rather than fractionated approach to these activities and, in the opinion of the Task Force, underscores the value of centralization and the need to reconsider the current definition of agency.
- Although MD 712 specifies that "*each agency with 3,000 or more employees should have a full-time handicapped program manager at headquarters and in each organizational unit and field installation with 3,000 or more employees,*" NIH does not have a person

> In July 1999, NIH centralized interpreting services. In the year preceding centralization, NIH (through the ICs) received a total of 388 requests for interpreting services. In the year following centralization, the total number of requests jumped to 1,058. The total cost for providing centralized services was $390,000.

assigned full time to the disability program, nor does it have staff assigned to overseeing implementation of the program.

- NIH does not have a centralized mechanism in place for the evaluation of individuals with disabilities or the provision of reasonable accommodation.
- NIH does not capitalize on its experience in providing reasonable accommodation. The lack of coordination across NIH leads to duplication of effort and inefficiencies in providing appropriate assistance as well as lower productivity. NIH has no "clearinghouse" for all disability issues (e.g., evaluation of individuals with disabilities, provision of assistive technologies, maintenance of an inventory of NIH-owned assistive property, parking, maintenance of accessibility during construction, way-finding).
- No formal mechanism exists for obtaining input from the affected communities. NIH lacks data on how many employees currently have disabilities and whether they have requested or have received reasonable accommodation.

Coverage

- In its most recent iteration, MI 2204 covers only NIH employees and applicants. It does not address the needs of other members of the extended NIH family, including, for example, visitors, Intramural Research Training Award (IRTA) and other fellows, and contractors. Although technically "reasonable accommodation" relates to employment, the Task Force interprets the term more broadly to include "access" to NIH programs and facilities. In some instances, such accommodation may take the form of ensuring physical access to a facility in which an NIH-sponsored event or work takes place. In others, accommodation may entail providing services to guests, visiting scientists, and others for whom NIH is responsible. For example, providing interpreting services for an NIH program open to the public would fall within the expanded definition. Likewise, when NIH engages a consultant or others in business transactions, NIH is responsible for providing access to its facilities, although the contractor would be responsible for providing the equipment or services needed by the consultant to perform his or her job.
- Although MD 712 emphasizes that employees with disabilities in the "targeted disabilities" categories receive priority for reasonable accommodation, it also requires agencies to address the needs of all agency staff with disabilities, not just those with targeted disabilities. To be a leader in this area, NIH needs to move to a more inclusive position than merely satisfying the letter of the law.

> "Targeted disabilities" include a number of severe disabilities such as missing limbs, deafness, blindness, full and partial paralysis, epilepsy, and spinal deformities. Only one percent of NIH staff fit this category.

Provision of Resources

- Although MD 712 requires agencies to establish separate and identifiable resources for providing reasonable accommodation, NIH has not addressed the issue of creating a specific budget to cover its cost.
- Both MD 712 and internal departmental policies maintain that funding for reasonable accommodation should come from the highest level in an agency. Although MI 2204 cites "undue hardship" as a valid rationale for not providing reasonable accommodation, except in an extreme case, it would be difficult, at best, for NIH to defend a decision denying the provision of reasonable accommodation based on cost, given the FY 2001 budget of over $20 billion.

- Although NIH has an identifiable line item for correcting facility deficiencies within the Buildings and Facilities (B&F) budget, it does not have a similar line item for providing reasonable accommodation. The process for requesting resources for these activities in the budget process is not clear.
- Currently at NIH, each IC pays for the reasonable accommodations needed by employees who participate in classes at the NIH Training Center. In contrast, other training facilities (for example, the Parklawn Training Center) provide reasonable accommodations centrally, on request, for employees attending training.
- NIH does not have a standard for the provision of reasonable accommodation at NIH-sponsored events. It is often difficult to obtain information about requesting reasonable accommodation for NIH events, and it is unclear how such accommodations are to be financed.

Information Dissemination and Followup

- Many employees and managers are unaware of and have no access to professional resources related to reasonable accommodation and the provision of assistive technologies.
- NIH does not have a well-developed or well-publicized program for managing surplus assistive devices such as visual and audio aids.

Recommendations Related to Reasonable Accommodation

On the basis of its review of the policies affecting reasonable accommodation at NIH, the Task Force on Disability recommends the following steps:

Definitions and Organization/Structure

- Clearly identify NIH as the "agency" responsible for ensuring reasonable accommodation and the ICs as "subcomponents" in the revised MI 2204.
- Establish a centralized NIH-wide Office on Disability within the Office of Research Services (ORS) with responsibility for:
  - Coordinating, tracking, and evaluating the provision of reasonable accommodations;
  - Developing and overseeing the implementation of uniform standards for the timely acknowledgment of requests for reasonable accommodation (e.g., 10 business days) and the timely provision of requested products and services;
  - Serving as an information resource and disseminating periodic instructions throughout NIH concerning procedures related to services for people with disabilities and the provision of reasonable accommodation;
  - Facilitating training on reasonable accommodation for supervisors and upper level management in conjunction with the Office of Equal Opportunity (OEO) and the Office of Human Resources Management (OHRM);
  - Functioning as the NIH focal point for the host of issues faced by people with disabilities at NIH facilities—from parking and way-finding to inclement weather;
  - Referring individual employees with grievances related to reasonable accommodation to Alternative Dispute Resolution or OEO if a formal grievance is to be filed;

- Keeping informed about and incorporating best practices from other governmental agencies and private sector organizations such as the Department of Defense Computer/Electronic Accommodation Program; and
- Maintaining an inventory of surplus assistive devices and publicizing their availability to NIH employees.

- Ensure that the centralized Office on Disability is recognized formally as the focus for all issues related to accessibility and services related to reasonable accommodation.
- Establish an Advisory Committee on Disability Issues in which at least 50 percent of the members are employees with a range of disabilities or supervisors of employees with disabilities. This could be a component of the existing ORS Advisory Committee, a modification to the Facilities Accessibility Advisory Committee, or a separate Advisory Committee. Seek input early on from these stakeholders when developing any future policies related to reasonable accommodation.
- Develop and widely distribute an annual report on reasonable accommodation prepared by the Office on Disability. The report should document services, costs, progress, successes, and areas needing improvement. As noted in the "Data Collection" section of this report, the office should ensure that confidentiality is maintained during the data collection process. It should also serve as the corporate repository of NIH activities in the area of reasonable accommodation and accessibility.
- As director for the new office, select an individual who has the confidence of the NIH Director, good contacts with the client community, a passion for disability issues, and knowledge of disability issues and resources as well as the workings of NIH (e.g., interrelationship among Human Resources, ICs, OEO, Division of Engineering Services [DES]/ORS; contracting and negotiation). Vet the position description with stakeholders to ensure that the right skill set is sought and include members of the NIH disabled community in the selection process.
- Establish a centralized funding mechanism and request funding annually through the Funding Advisory Review Board (FARB) process. Because the FARB has made preliminary decisions for FY 2002 and 2003, funding for the office should be provided in the short term through use of the NIH Director's one-percent transfer authority.

  Under the proposed plan, each IC's contribution would be in proportion to its total "employee census" relative to the entire NIH population. Inclusion of reasonable accommodation as a central service item is consistent with the recent review of centrally provided services contained in the report, *National Institutes of Health: Centrally Funded Services—A New Process,* prepared in November 1998 by the Management Fund/Service and Supply Fund Committee, co-chaired by Dr. Ruth Kirschstein, Deputy Director, NIH, and Anthony L. Itteilag, Deputy Director for Management, NIH. That report affirmed that, in addition to efficiencies and economies of scale and knowledge, centralization helped "*ensure that the entire NIH community can have equal access to these services.*" This approach is also consistent with "best practices" employed by leading corporations in implementing the requirements of ADA. For example, Fannie Mae, the largest supplier of home mortgages and, generally, the largest supplier of debt in the United States, centralized these services 3 years ago. Before that, as is the case with NIH now, support for reasonable accommodation was provided by each "local" budget.
- Support NIH in its efforts to become **the model** Federal agency for removing barriers to the hiring and full employment of individuals with disabilities and build a proactive approach to increasing the visibility of this goal through marketing and other techniques.

- Provide, through a contract, the necessary skills to independently assess individuals with disabilities for reasonable accommodation determinations. Use the same mechanism to provide current information about constantly changing assistive technologies. To identify potential offerors, ORS should consider issuing either a Sources Sought Synopsis through *Commerce Business Daily* or a purchase order to a not-for-profit entity to conduct a management assessment of available providers. Individuals with disabilities should participate in drafting the statement of work for these contracts and in evaluating the proposals received.
- Disseminate information on the NIH reasonable accommodation process widely and draw attention to accessibility issues by improving the visibility of these services in the NIH phone book, on the NIH home page, through presentations to Institute Directors, Scientific Directors, Executive Officers, Personnel Officers, Grants Management Advisory Committee, Extramural Program Management Committee, Extramural Administrative Officers, Intramural Administrative Officers, and others.
- Require followup calls to clients and supervisors as standard practice to ensure that recommended actions have been taken.
- Create a checklist of reasonable accommodation needs for all events, agency-wide briefings, and open meetings held on the NIH campus. The checklist should include items such as wheelchair access, interpreters, open captioning, and lighting and should be completed *before* obtaining permission to reserve a room. Develop an enforcement mechanism to hold the sponsoring office or organization accountable for complying with checklist requirements. Also, consider ways to deal with inaccessible events during the transition to the new policy.

Coverage

- Revise MI 2204 to include other members of the NIH community such as visiting scientists, guests, and IRTA and other fellows, or issue a concomitant MI to cover them.

Provision of Resources

- Assign at least one full-time staff to head the new Office on Disability.
- Modify the "undue hardship" clause in the revised MI 2204 to indicate that NIH expects this justification to be used only in the most unusual cases.

Information Dissemination and Followup

- Overall, the recently revised MI 2204 does an excellent job of broadly defining responsibilities for the provision of reasonable accommodation. However, if the structural changes recommended in this report are adopted, the manual should be reviewed and revised to reflect the new centralized responsibility for reasonable accommodation, the involvement of the Advisory Committee, and enhanced coverage. In addition, the revision should specifically address appropriate timelines for responding to requests, streamlined procedures for making requests (e.g., elimination of the need for repeated written requests for aids such as large-print documents that will be needed on an ongoing basis) and the role of the requesting employee and direct supervisor in that process, the request denial and appeals process, and strategies for publicizing the availability of and steps involved in obtaining reasonable accommodation to the full NIH community.

Facilities Accessibility

Accessible facilities are free of barriers that impede people with disabilities from safely entering a building and using it productively for its intended purpose. Architectural and other physical barriers include elements such as protruding furniture and equipment, inaccessible towel dispensers and telephones, narrow doorways, raised door jambs, unpaved walkways, and inaccessible parking.

From 1996 to 2001, the NIH Architectural Barriers Compliance program, a line item of the NIH B&F budget, received $4.5 million. The President's FY 2002 budget includes $1.0 million in the B&F budget for the program. Currently phase 1 of the Bethesda campus-wide facility accessibility survey has been completed and is being reviewed by the Facility Accessibility Advisory Committee (FAAC) for prioritization of correction actions and funding (the FAAC is described in the section on "Enhancing Responsiveness and Increasing Input," p. 10). Additional phases of the survey will include other NIH campus and leased facilities.

Policy Background

Architectural Barriers Act: In 1968, the Congress passed the Architectural Barriers Act, one of the first efforts to ensure access to the built environment. The act requires that buildings and facilities designed, constructed, altered, or leased with certain Federal funds be accessible to persons with disabilities.

Uniform Federal Accessibility Standards: The General Services Administration (GSA), Department of Defense, U.S. Postal Service, and Department of Housing and Urban Development are responsible for developing the Uniform Federal Accessibility Standards (UFAS), which are used to enforce the act. The Architectural and Transportation Barriers Compliance Board, usually referred to as the Access Board, develops and updates the guidelines that govern the standard-setting work of the four agencies. NIH buildings and facilities must comply with those standards.

The UFAS include extensive specifications, such as detailed drawings, definitions, and dimensional tolerances. The standards address everything from space allowances, accessible routes, surfaces, parking and passenger loading zones, signage, and telephones to alarms, lavatories, doors, and windows. Sections of the standards are specific to health care buildings and facilities, restaurants and cafeterias, and libraries. In some places, the standards delineate how many of a certain feature or item must be present—for example, how many accessible parking spaces must exist for Federal facilities of specified sizes or numbers of occupants.

Other Federal, State, and local standards: The UFAS govern space occupied by NIH within leased facilities built by commercial developers. However, the standards implementing the ADA of 1990 apply to those portions of the building that NIH does not lease, such as entrances and common-use areas like lobbies and restrooms. In addition, developers and/or occupants of leased commercial facilities must comply with the accessibility standards in applicable State and local codes. Such standards must meet, but may also exceed, the ADA standards. For example, standards in Montgomery County, Maryland—the location of the NIH campus—exceed those of ADA.

American National Standards Institute barrier-free design standards: In 1987–88, the four responsible agencies reexamined the UFAS to assess consistency with standards developed by the American National Standards Institute (ANSI), a nongovernmental national organization. ANSI convened a

committee composed of 52 organizations representing associations of people with disabilities, rehabilitation professionals, design professionals, builders, and manufacturers to devise standards for barrier-free design. The standards are called ANSI A117.1, "Specifications for Making Buildings and Facilities Accessible to, and Usable by, Physically Handicapped People." It is important to note that the UFAS meet or exceed the ANSI specifications.

Impact of funding on accessibility: Section 504 of the Rehabilitation Act of 1973 also prohibits discrimination on the basis of disability in programs or activities conducted by Federal agencies or by non-Federal organizations that receive Federal funds. This means that NIH-supported activities and services must be accessible to persons with disabilities, whether they are intended for NIH staff or provided to the members of the larger community.

Issues Related to Facilities Accessibility

The Task Force on Disability identified two primary issues that have affected efforts to improve facility accessibility at NIH. The first relates to NIH's ability to coordinate and fund costly efforts governed by standards and guidelines from multiple sources. The second involves the need to increase responsiveness and obtain input from experts on and NIH constituencies affected by facility accessibility.

Coordination and Funding

- Many NIH facilities—both owned and leased—are not accessible for people with disabilities. A review of the existing NIH Architectural Barriers Compliance Program conducted in the late 1990s indicated the need for a more tailored and coordinated approach to evaluating, monitoring, and improving facility accessibility at the NIH campus and at facilities leased by NIH. In response, NIH established the Facility Accessibility Program (FAP) in the DES to oversee all facility accessibility issues covered by, but not limited to, the Architectural Barriers Act and the UFAS, as well as the ADA Accessibility Guidelines (ADAAG).
- Because the alterations needed to improve accessibility are costly, sufficient funding is a continuing issue. The FY 2002 budget request includes $1.0 million to "eliminate barriers to persons with disabilities" under the Building and Facilities Program.
- The events of September 11 have heightened sensitivity to how NIH plans for the safe evacuation of individuals with disabilities from its facilities.

Enhancing Responsiveness and Increasing Input

- NIH has established the FAAC under the purview of the FAP. FAAC membership includes NIH employees with disabilities, NIH managers, and outside experts in architecture, facility management, and all facets of accessibility compliance. In addition to representation from the Clinical Center and seven Institutes, the FAAC roster includes representatives from the Civil Rights Division, Department of Justice; Office of Technical and Information Services; the Access Board; and the Commission on People with Disabilities, Montgomery County Government. A consultant architect who specializes in UFAS and ADA also serves on FAAC.
- The FAAC helps ensure that the FAP applies UFAS and ADAAG appropriately in the planning and design of future construction projects and in the maintenance of existing NIH buildings and facilities. It also ensures that FAP conducts accessibility surveys in accordance with UFAS and ADAAG and assigns the appropriate priority to corrective actions. When the FAP identifies complex or unique

facility accessibility issues or they are brought to its attention through the hotline, the FAAC provides its perspective and assists the FAP in developing specialized solutions.

Recommendations Related to Facilities Accessibility

The Task Force offers the following recommendations to support improved facility accessibility and achieve "universal access." Rather than merely complying with Federal standards for facilities accessibility and safety, NIH has set universal access as its goal. Universal standards of access emphasize the practical and economic benefits to all when buildings and facilities are accessible to people with disabilities. In the recent *Report of the Task Force on Disability Awareness*, the NIH Diversity Council made a series of specific recommendations that were designed to apply the concept of universal access into practices adopted by NIH. Relevant recommendations are repeated here.

Coordination and Funding

- Develop and implement training in the UFAS for NIH Executive and Administrative Officers so they understand the kinds of activities involved in addressing facility accessibility and the resources required to support it.
- Revisit the annual level of resources sought from Congress for barrier removal on the basis of the findings from a survey of all NIH-owned and -leased facilities in process now. Develop plans for the budget and implementation of corrective actions for facilities accessibility.
- Issue an annual report delineating the accessibility and safety milestones that were met and their timeframe and cost. The report should also describe the plan for the coming year with milestones and projected costs and should include contact information for those responsible for each accessibility project.
- Continue to support the FAP. In accordance with GSA parking regulations, UFAS, and ADA regulations, the Diversity Council recommended that NIH clearly commit to adequate numbers of, appropriate width for, and appropriate locations for parking spaces designated for people with disabilities at leased and NIH-owned facilities. Depending on whether a building or facility is used by the general public and on the number of occupants who regularly work there, a standard minimum number of designated parking spaces is to be set aside as specified in the UFAS and ADA standards. The Diversity Council noted that additional identified need should **automatically** result in the addition of an appropriate number of spaces, regardless of how many regular spaces would be lost in the process. The Council also said that **NIH policy should mandate the provision of access for visitors and employees with disabilities as the highest priority parking imperative**. *In response, the DES established the FAP to make all facilities owned and leased by NIH more accessible to both employees and visitors. The FAP and its Advisory Committee are also working collaboratively to evaluate, monitor, and improve facility accessibility at NIH to ensure that facilities not only comply with the UFAS, the ADAAG, and the Architectural Barriers Act, but also respond to issues unforeseen in those standards and legislation.*
- Recognize that temporary construction poses facilities accessibility problems and develop plans to respond. The Council's report emphasized that construction-associated disruptions can and do create significant difficulties for people and recommended that plans for maintaining accessibility during construction should be a mandatory part of the preparation process. Plans should include all aspects of accessibility from safety, signage, and transportation to actual accessibility of paths, points of

entrance and egress, and transportation. If standard approaches to providing accessibility are not feasible due to construction constraints or activity, acceptable alternatives should be proposed, then reviewed and accepted by an expert on accessibility. *Under the purview of the FAP, the FAAC has been established. The FAAC consists of employees with disabilities, NIH managers, and outside experts in architecture, facility management, and all facets of accessibility regulatory compliance. In addition, the FAP is in the process of updating the "NIH Design Policy and Guidelines and Standards for Temporary Construction."*

- Establish a mechanism for coordinating and improving response to facility accessibility inquiries. During the duration of major construction on the NIH campus, the report recommended that NIH establish a central phone number for personalized transportation services for individuals with disabilities (especially those with mobility and sight impairments) to assist them in moving from building to building, particularly those not directly on the shuttle bus route (for example, it would be difficult, at best, to go from Building 12A to Stone House via shuttle). *Although not specifically dedicated to construction issues, DES has established a Facility Accessibility Hotline (301-402-3472) to improve response to facility accessibility inquiries.*
- Review NIH procedures and those of the individual ICs with regard to the evacuation of staff from NIH-owned and -leased facilities during emergency situations. If necessary, request funding for any needed improvements through available emergency assistance funds.

Enhancing Responsiveness and Increasing Input

- Provide universal access to all NIH-owned and -leased facilities; begin this process by focusing first on new facilities and methodically removing all existing barriers.
- Develop a formal process to review, assign priorities to, and implement corrective actions.
- Develop and implement tools to facilitate electronic, print, and audio communications on a wide range of accessibility topics for NIH employees, visitors, and patients. Tools include items such as Web pages, maps, and brochures.
- In conjunction with the FAAC, develop a publicity plan for the FAP hotline.
- Complete the update of the "NIH Design Policy and Guidelines and Standards for Temporary Construction." Review previous requests for reasonable accommodation to ensure that the update responds to them.
- Survey the accessibility needs of people with disabilities who work at or use services provided on the NIH campus. The Council's report recommended a survey of employees with disabilities to identify shortcomings and needs associated with on-campus and off-campus shuttle services. Survey results would indicate, for example, whether shuttle buses were properly equipped to be fully and routinely accessible to people with disabilities and whether bus stops were appropriately designed and featured clear signage to enable people with disabilities (and others) to use transportation safely and without hassles. Depending on the number of deficiencies identified in the survey and the time and costs involved in rectifying them, the Council recommended that NIH provide alternate forms of transportation such as accessible taxis at no charge to people with disabilities until appropriate changes can be made. In addition, the report also said that in-service training should be provided twice annually to all drivers on the use of equipment and to enhance sensitivity to the needs of riders with disabilities. *Under the purview of the new FAP, Phase I of a campus wide accessibility survey*

was undertaken and completed to evaluate compliance with UFAS and to address accessibility concerns that are not covered by UFAS.

- Develop comprehensive standards for signage that promote universal facilities accessibility. The Council report recommended that NIH obtain input from focus groups of individuals with disabilities and outside experts to use in developing a comprehensive set of standards for signage in and around all NIH buildings and facilities, whether owned or leased. Such standards would identify where signs are located, what size and types of lettering—including Braille—the signs should use, and what aspects of "way-finding" should be included on the signs, such as the way to the nearest teletypewriter telephone, the nearest wheelchair-accessible restroom, and the safest path between points on campus. *Currently, the FAP is working with Medical Arts to develop standards for interior room signage.*

Recruitment, Hiring, Career Development, and Work Life

The timely provision of reasonable accommodation makes NIH a more attractive place to work for people with disabilities. Providing reasonable accommodation and improving facilities accessibility will help ensure that an individual with disabilities receives the full benefits and entitlements of employment. These entitlements encompass training and career advancement opportunities and remain the purview of the OHRM and the individual ICs.

Policy Background

The Rehabilitation Act of 1973: The act established the first Government requirement for the **planned and targeted employment** of persons with disabilities. Specifically, Section 501(b) states:

> *"Each department, agency, and instrumentality...in the executive branch shall...submit to the Commission and to the Committee an affirmative action program plan for the hiring, placement, and advancement of individuals with disabilities in such department, agency, or instrumentality. Such plan shall include a description of the extent to which and methods whereby the special needs of employees who are individuals with disabilities are being met. Such plan shall be updated annually, and shall be reviewed annually and approved by the Commission if the Commission determines, after consultation with the Committee, that such plan provides sufficient assurances, procedures, and commitments to provide adequate hiring, placement, and advancement opportunities for individuals with disabilities."*

Special hiring authorities: The Office of Personnel Management responded to the act by creating special hiring authorities and then a conversion authority. In addition, the work and life policies and programs established to help all employees integrate work and home life have also been used to help employees with disabilities.

Executive Orders 13163 and 13164: The most recent initiatives relating to the Federal Government's employment of individuals with disabilities are EO 13163, which increased opportunities for individuals with disabilities, and EO 13164, summarized previously. EO 13163 set a goal of hiring 100,000 qualified individuals with disabilities to work in the Federal Government over the next 5 years. The NIH portion of that goal is 945 of a total departmental goal of 3,500. These numbers refer to new hires and not to reassignments or transfers from other Federal agencies.

Issues Related to Hiring, Training, Career Development, and Work Life

Issues emerging from the review of data and history on the employment of individuals with disabilities at NIH, as well as an analysis of best practices of other Government agencies and private organizations, include the following:

- Over the past 4 years, there has been no percentage increase in the employment of persons with disabilities at NIH. The overall percentage averages 5.8 percent and the average of employees with targeted disabilities is 1.2 percent. The number of employees reporting disabilities increased from 708 to 760 and from 169 to 179 for employees reporting targeted disabilities. Although the numbers have increased modestly, the overall employee population at NIH also continues to grow so that these percentages are "stagnant."
- Most employees with disabilities at NIH are in the GS-5 to 8 and GS-9 to 12 grades. No data are available for individuals in the administratively determined pay plan, which accounts for many NIH scientists.
- NIH has taken two approaches to the recruitment and placement of persons with disabilities over the past 20 years. During the first 10 years, the system was highly centralized in OHRM and later the Division of Personnel Management with a ½ FTE dedicated to the function. Monthly meetings of selective placement coordinators were held, an applicant supply file was maintained, and close contact was established with appropriate divisions such as Vocational Rehabilitation. From 1989 to 1995, responsibility increasingly shifted to IC Personnel Offices with complete decentralization occurring in the late 1990s. Currently OHRM addresses policy issues and provides advice, assistance, and information about selective placement programs and conferences to IC staff.
- No information is currently available about the career progression of employees with disabilities.
- According to MD 712 7d(7), "Agencies are to provide or obtain training and technical assistance adequate to develop and maintain a high level of management, supervisory, and employee awareness of issues, policies, regulations, and procedures concerning affirmative action for handicapped individuals." NIH does not have a well-articulated policy and followup plan for this type of training, and training is not routinely offered or provided to supervisors for dealing with disability issues.
- Organizations with exemplary track records in employing persons with disabilities have centralized programs for recruitment and reasonable accommodation.

Recommendations Related to Hiring, Training, Career Development, and Work Life

The recommendations that follow are made with the understanding that management is ultimately responsible and must be accountable for hiring highly qualified people with disabilities. Although a pool of excellent candidates may be recruited, the hiring decision rests with the supervisor. Career development, likewise, is a shared responsibility, but the supervisor must assist the process. If NIH is serious about increasing the number of people with disabilities in the workforce and ensuring their representation throughout the organization from SES to GS-1, then the Director of NIH must state this goal clearly and hold the Institute Directors accountable for achieving it.

- Establish a centralized resource for recruitment and placement of qualified persons with disabilities for consideration when filling vacancies and assist persons with disabilities interested in finding employment with NIH. This could be done either with Federal staff or via contract under the auspices of OHRM.
- Encourage the use of databases, applicant supply pools, and the Internet to increase recruitment and facilitate the interview process and to coordinate with the Division of Vocational Rehabilitation and employment firms that specialize in placing people with disabilities.
- Implement the previous recommendation to fund reasonable accommodations centrally as one incentive for encouraging managers to select qualified candidates with disabilities.
- Develop a centralized career development program through OHRM using the Technical IRTA or the Management Intern Program as models. This program could train people with disabilities by rotating them throughout NIH in an appropriate capacity (e.g., scientific support, administration). The program would not guarantee placement at NIH but would provide experience so that trainees could apply for positions at NIH, other Federal agencies, or the private sector.
- Provide reasonable accommodation on request for all courses provided through the NIH Training Center and publicize this policy in every training announcement. There should be no surcharge for this service, even if implementation of this recommendation increases the average fee per course. Spread out across the entire NIH, such increases should be minimal.
- Develop practical in-service training on reasonable accommodation and other aspects of EEO requirements to which all IC managers and supervisors can subscribe. As is the case currently, attendance at EEO-related training helps satisfy the EEO element in the performance appraisal of IC management.
- Enhance the capacity of all current NIH training programs to recruit persons with disabilities. Although programs such as the NIH Academy, the Management Intern Program, the Presidential Management Intern Program, and the Management Cadre Program do an excellent job of selecting women and members of racial and ethnic minorities, they have been less successful in recruiting people with disabilities whether inside or outside NIH.
- Increase and specifically target the mentoring and career counseling programs offered by the Work and Family Life Center to employees with disabilities.
- Develop centralized training opportunities for those who supervise employees with mental or cognitive disabilities so that they can provide appropriate coaching and reasonable accommodations. Expand the use of the Employee Assistance Program (EAP) for employees needing counseling, initial evaluation, individualized work plans, support groups, and referrals to community resources. This function could be provided internally by the EAP or through a contract with an outside agency.
- Make telecommuting available to more employees, particularly those with disabilities who may need it for purposes of reasonable accommodation.

Information Technology

When applied to people with disabilities, information technology includes the array of computers, software, Web-based applications, telecommunications devices, and video and multimedia products that facilitate full participation in the workplace and in the services and activities available to people without disabilities. Telecommuting, a boon to numerous employees, offers special advantages to people with disabilities because it eliminates the barriers posed by lack of appropriate transportation and worksites that are not fully accessible.

Among the best known telecommunications devices are teletypewriters (TTYs), which employ interactive text-based communications through the transmission of coded signals across the telephone network to help people with hearing disorders communicate with others. Other TTYs include telecommunications display devices and computers with special software. Telephone relay services are another communications option that can be used when hearing people do not have their own TTY. Information technology holds genuine promise for people with disabilities, but technology innovators and purveyors, as well as purchasers, must be made aware of its potential and held accountable for both developing it and making it fully available to individuals with disabilities.

Policy Background

Rehabilitation Act Amendments: In 1998, the Rehabilitation Act Amendments strengthened Section 508 of the Rehabilitation Act by requiring access to electronic and information technology provided by the Federal Government. The amendments state that both employees and members of the public with disabilities must have access to this technology unless this places an "undue burden" on the agency.

U.S. Architectural and Transportation Barriers Compliance Board (Access Board): In December 2000, the Access Board published new standards covering Section 508 of the Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998. Section 508 states that when Federal agencies develop, procure, maintain, or use electronic and information technology, they must ensure that Federal employees and members of the public with disabilities have access to and use of information and data that are comparable to the access and use provided to individuals without disabilities unless an undue hardship would be imposed on the agency.

Revised NIH Policy Manual Issuance on Reasonable Accommodation: NIH MI 2204 (August 2001) ensures access to information technology as mandated in the Rehabilitation Act Amendments.

Section 508 Standards: The standards use the Federal procurement process to ensure that technology acquired by the Federal Government is accessible. They contain enforcement provisions that became effective on June 21, 2001, and set up an administrative complaint process for noncompliance.

Technology areas covered by the Section 508 standards include:

- Software applications and operating systems,
- Web-based intranet and Internet information and applications,
- Telecommunication products,
- Video and multimedia products,

- Self-contained, closed products, and
- Desktop and portable computers.

Issues Related to Information Technology

- Although the Section 508 standards are to be applied prospectively and do not require Federal agencies to retrofit existing electronic and information technology, reasonable accommodations still need to be provided if they are requested.
- Currently there are few Section 508-compliant products on the market.
- NIH policy requires open and closed captioning on all videos, but that policy is not well publicized and compliance is not universal.

Recommendations Related to Information Technology

In its December 1998 report on disability awareness, the NIH Diversity Council addressed electronic and information technology. The recommendations that follow, prepared by the Information Technology Management Committee, should be viewed as additions to that report. Currently OEO is responsible for policy development relative to Section 508 at NIH. As recommended elsewhere in this report, the coordination of service provision relative to Section 508 will be centered in the new Office on Disability with appropriate consultation with the Center for Information Technology (CIT).

Recommendations Specific to Section 508 Standards

- Assign to the new Office on Disability the responsibility for linking employees to appropriate assistive technologies needed to provide the reasonable accommodation outlined in Section 508. CIT will continue to provide guidance and direction to NIH on Section 508 standards.
- Request resources to establish a permanently staffed position to manage the implementation of Section 508 throughout NIH. This position should be part of the new Office on Disability.
- Continue to work with the ICs to make their resources compliant with Section 508.
- Develop a communications plan for disseminating information on this issue to NIH employees.
- Continue the Office of Acquisition Management and Policy's role in educating IC acquisition officials about the Section 508 standards. Include clauses in all NIH procurements concerning compliance with Section 508.
- Ensure that all NIH training facilities make one workstation fully accessible to people with a range of disabilities and that training materials are accessible and available in alternate formats.
- Ensure that NIH employees with disabilities receive technical support that is comparable in quality to that received by employees without disabilities; train technical support staff to make assistive technologies work with standard desktop software.
- Educate IC staff involved in micropurchasing decisions to purchase Section 508-compliant devices whenever possible.

Recommendations Specific to Telecommunications and Multimedia Products

- Increase the use of TTYs in the ICs, particularly in Human Resource and Public Information Offices and on hotlines for the public; train staff in receiving and sending calls with this equipment.
- Ensure that telecommunications equipment purchased in large contracts under the purview of the Office of Acquisition Management and Policy and CIT contracting personnel is as compliant as possible within the bounds of available technology.
- Encourage vendors under the purview of the Office of Acquisition Management and Policy and CIT contracting personnel to develop accessible versions of their products.
- Inform the ICs about the requirement to install accessible telecommunications equipment or upgrade it to the most accessible technology available.
- Inform IC personnel involved in new construction or renovation of their responsibility to provide accessible telephone equipment including courtesy phones, house phones, and emergency phones in public spaces such as lobbies, elevators, and parking lots.
- Ensure that switchboard operators receive ongoing training in responding to and directing TTY calls; they should also receive updated lists of available TTY numbers on the NIH campus.
- Ensure that IC staff members trained in the use of TTYs and relay services are available to respond to inquiries.
- Consider accessibility issues when purchasing telephones and other communications devices, especially if every employee is required to use them.
- Ensure that every Web page and publication supplies a TTY number as part of the contact information provided.
- Widely publicize the policy requiring open and closed captioning of all videos, movies, and other multimedia products produced by or shown on campus. Because increased sensitivity to this issue is needed, reminder notices should be sent periodically.

Data Collection

Because the collection of data on employees with disabilities at NIH has been inconsistent and incomplete, it has impaired NIH's ability to measure and assess its progress in hiring, retaining, promoting, and accommodating individuals with disabilities. Although the problem is both complex and difficult to solve, it should not deter NIH from testing new approaches to improving data collection. Periodically, attempts have been made to increase effectiveness, but those efforts have met with limited success. Data sources include Standard Form 256: Self-Identification of Handicap (SF-256) and reasonable accommodation requests, including applications for accessible parking for those with a qualifying disability (a copy of SF-256 may be found in Appendix B).

Policy Background

All information submitted by individuals with disabilities for purposes of data collection is confidential and is protected under 29 CFR 1360.

The current process for collecting data on employees with disabilities hinges on an employee's willingness to voluntarily complete SF-256, which he or she receives during the orientation provided by the Human Resources Office. When Human Resources receives a completed form, a clerk enters the data into the central NIH database.

Seven years ago, after recognizing that many employees had not completed the form, NIH conducted a campaign to encourage them to do so. The campaign did not achieve its goal and the data remained incomplete.

Issues Related to Data Collection

- Employees with untargeted disabilities seldom complete SF-256, possibly because they do not think they have a disability, are sensitive about their disabilities (e.g., mental illness, cancer, AIDS), have concerns about the confidentiality of the information they impart, or do not think they would gain anything by completing the form.
- SF-256 is a **voluntary** form that collects data on all **new** staff members, either permanent or temporary.
- SF-256 does not collect data on Commissioned Officers.
- There is little connection between the data collected by SF-256 and the data collected by the NIH Parking Office on handicapped parking permit holders. A recent check of the central NIH database revealed that of 177 employees with handicapped parking permits, only 2 had self-identified as having a disability on the SF-256.
- ICs are inconsistent about encouraging employees to complete an SF-256 when they are requesting a reasonable accommodation.
- Currently, the number of individuals with access to data on reasonable accommodation exceeds the number with a bona fide need to know.

Recommendations Related to Data Collection

- OEO will review the current methods that NIH and the ICs use to collect data on employees with disabilities and make recommendations for improving the process on the basis of best practices used within NIH and by other agencies. OEO, working with OHRM, the new Office on Disability, and the ICs, should conduct the review in conjunction with representatives of the disabled community. The purpose of the review is to develop new methods for capturing more complete and accurate information on the totality of persons at NIH with disabilities. This could include techniques such as an anonymous on-line survey, perhaps based on the content of SF-256, but modified to include questions about reasonable accommodation.

- The new Office on Disability will compile data on the number and types of requests for reasonable accommodation, whether granted or denied, and maintain information on:
  - Jobs (e.g., occupational series, grade level, agency component) for which reasonable accommodation has been requested;
  - Types of reasonable accommodation requested for each job;
  - Number and types of reasonable accommodation for each job, by agency component, that were approved and denied;
  - Number and types of requests related to the benefits or privileges of employment and whether they were granted or denied;
  - Reasons for denying requests;
  - Amount of time required to process each request; and
  - Requests for flexi-time, flexi-place, and reassignment based on reasonable accommodation.
- Develop a method for collecting non-FTE data, perhaps by using the SF-256.
- Develop a method for collecting data on Commissioned Officers.
- Ensure that access to any data collected is restricted to those with a genuine need to know. Under no circumstances should supervisors receive medical information pertaining to requests for reasonable accommodation; medical information should be maintained in a separate file.
- Initiate a new campaign to encourage all employees with disabilities to complete SF-256. The campaign should:
  - Make the form available on-line so that employees can complete it and return it easily to their IC Human Resources Office. The on-line form should include a reference to the NIH Disability Awareness On-Line Training Module, which should be operational by December 2001.
  - Emphasize that the data collected on the SF-256 will be secure.
  - Reinforce the idea that information collected on the SF-256 is essential to making NIH facilities more accessible (e.g., determining the number of handicap-accessible parking spaces) and ensuring adequate services are requested to make facilities accessible.
- Develop a communications strategy that explains the reasons for the campaign and the need for employees to update the information on the SF-256 as circumstances change.
- Strongly encourage employees to complete the SF-256 when they request a reasonable accommodation or apply for a special parking permit.
- Educate staff members responsible for collecting and processing data about the fact that maintaining confidentiality is a priority and violations will be subject to sanctions.
- Collect copies of the handicapped parking applications form from the NIH Parking Office and ask OEO to compare them with the data from the SF-256s.

APPENDIX A

Legislation, Directives, and Standards Affecting Reasonable Accommodation at NIH

Legislation/ Directives/Standards	Key Provisions	Covers NIH		Comments/Caveats
		Yes	No	
Architectural Barriers Act	Requires buildings/facilities designed, constructed, or altered with certain Federal funds to be accessible to people with disabilities	✓		Mandates generically accessible buildings/facilities for persons with disabilities
Uniform Federal Accessibility Standards (UFAS)	Define standards enforcing Architectural Barriers Act and governing space occupied by NIH within leased, commercial buildings	✓		Set specific standards for items like doors and parking spaces but do not cover renovation, demolition, infrastructure limitations, or historical preservation
Rehabilitation Act of 1973	■ Mandates reasonable accommodation for employees in executive branch of Federal Government ■ Prohibits discrimination on basis of disability in Federal programs or programs receiving Federal funds	✓		■ Sets first Government requirement for planned, targeted employment of people with disabilities ■ Mandates accessible NIH-supported activities/services whether for employees or larger community
Management Directive 712 (issued by EEOC)	■ Prescribes procedures for facilitating equal employment in Federal Government for people with disabilities ■ Requires agencies to publicize procedures, respond efficiently to requests, assign staff, identify resources for providing reasonable accommodation	✓		Specifies organizational approach for implementing reasonable accommodation, but NIH has not assigned a full-time person to or created specific budget to cover cost of disability program
American National Standards Institute (ANSI) Barrier-Free Design Standards	Specify building and facility accessibility standards for persons with physical disabilities		✓	UFAS meet or exceed ANSI standards
Americans with Disabilities Act (ADA)	Enacted disability laws for private sector/public facilities	✓		Covers common areas in NIH-leased facilities, plus space NIH does not lease
ADA Accessibility Guidelines (ADAAG)	Set accessibility guidelines for public/commercial buildings/facilities as required by ADA	✓		Apply to common areas in NIH-leased facilities; effectively implement ADA
Rehabilitation Act Amendments (Section 508 as amended by Workforce Investment Act of 1998)	Require comparability of electronic/information technology provided by Federal Government to persons with/without disabilities	✓		Address NIH employees with disabilities' accessibility to/utility of computers and other information technology devices/services

Legislation, Directives, and Standards Affecting Reasonable Accommodation at NIH (continued)

Legislation/ Directives/Standards	Key Provisions	Covers NIH		Comments/Caveats
NIH Policy Manual Issuance on Reasonable Accommodation (MI 2204)	■ Mandates reasonable accommodation for NIH employees/applicants to perform job safely and productively ■ Cites "undue hardship" as reason for not providing reasonable accommodation	✓		■ Places first line of responsibility for reasonable accommodation with ICs ■ Complies with Rehabilitation Act Amendments
Enforcement Provisions for Section 508 standards of the Rehabilitation Act Amendments	Define standards for enforcing access to information technology for people with disabilities	✓		Use Federal procurement process to ensure Federal Government acquires accessible technology; do not require retrofitting of existing technology
Executive Order 13163	Increases opportunities for individuals with disabilities to work in Federal Government	✓		Specifies that NIH will employ 945 people with disabilities as new hires—not transfers or reassignments—within 5 years
Executive Order 13164	Established procedures to facilitate provision of reasonable accommodation to: ■ job applicants with disabilities ■ employees to perform essential position functions, enjoy employment benefits/privileges equal to employees without disabilities	✓		Promotes concept of a "model Federal workplace" with respect to disabilities
Policy Guidelines on Executive Order 13164 (issued by EEOC)	Explain requirements of Executive Order 13164	✓		Describe implementation of Executive Order requirements
Enforcement Guidelines on Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act (issued by EEOC)	Explain ADA enforcement procedures	✓		Apply to common areas in NIH-leased facilities as well as space NIH does not lease
Revised NIH Policy Manual Issuance on Reasonable Accommodation (MI 2204)	■ Establishes guidelines to facilitate provision of reasonable accommodation at NIH ■ Ensures access to information technology as required by Amendments to Rehabilitation Act	✓		■ Implements Executive Order 13164 at NIH; covers NIH employees and applicants, but not fellows, IRTAs, contractors, visitors ■ Continues to cite "undue hardship" despite NIH budget
State/local standards governing accessibility to buildings/facilities	■ Set standards that must meet but may exceed ADAAG		✓	In NIH-leased buildings, apply to space, including common areas, that NIH does not lease
29 CFR 1360	Protects information submitted by persons with disabilities	✓		Applies to information on SF-256 and other forms or requests related to reasonable accommodation

APPENDIX B

SELF-IDENTIFICATION OF HANDICAP

(See instructions and Privacy Act information on reverse)

Last Name, First Name, Middle Initial	Birth Date *(Mo./Yr.)*	Social Security Number	ENTER CODE HERE →

DEFINITION OF A HANDICAP: A person is handicapped if he or she has a physical or mental impairment which substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Those handicaps that are to be reported are listed below (codes in bold numbers 13 through 94). In the case of multiple impairments, choose the code which describes the impairment that would result in the most substantial limitation.

TO THE EMPLOYEE: Self-identification of handicap status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.

01 I do not wish to identify my handicap status. *(Please read the employee note above and the reverse side of this form before using this code.)* (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.)

05 I do not have a handicap.

06 I have a handicap but it is not listed below.

SPEECH IMPAIRMENTS

13 Severe speech malfunction or inability to speak; hearing is normal *(Examples: defects of articulation [unclear language sounds]; stuttering; aphasia [impaired language function]; laryngectomy [removal of the "voice box"])*

HEARING IMPAIRMENTS

15 Hard of hearing *(Total deafness in one ear or inability to hear ordinary conversation, correctable with a hearing aid)*

16 Total deafness in both ears, with understandable speech

17 Total deafness in both ears, and unable to speak clearly

VISION IMPAIRMENTS

22 Ability to read ordinary size print with glasses, but with loss of peripheral (side) vision *(Restriction of the visual field to the extent that mobility is affected–"Tunnel vision")*

23 Inability to read ordinary size print, not correctable by glasses *(Can read oversized print or use assisting devices such as glass or projector modifier)*

24 Blind in one eye

25 Blind in both eyes *(No usable vision, but may have some light perception)*

MISSING EXTREMITIES

27 One hand

28 One arm

29 One foot

32 One leg

33 Both hands or arms

34 Both feet or legs

35 One hand or arm *and* one foot or leg

36 One hand or arm *and* both feet or legs

37 Both hands or arms *and* one foot or leg

38 Both hands or arms *and* both feet or legs

NONPARALYTIC ORTHOPEDIC IMPAIRMENTS

(Because of chronic pain, stiffness, or weakness in bones or joints, there is some loss of ability to move or use a part or parts of the body.)

44 One or both hands

45 One or both feet

46 One or both arms

47 One or both legs

48 Hip or pelvis

49 Back

57 Any combination of two or more parts of the body

PARTIAL PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

61 One hand

62 One arm, any part

63 One leg, any part

64 Both hands

65 Both legs, any part

66 Both arms, any part

67 One side of body, including one arm and one leg

68 Three or more major parts of the body *(arms and legs)*

COMPLETE PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

70 One hand

71 Both hands

72 One arm

73 Both arms

74 One leg

75 Both legs

76 Lower half of body, including legs

77 One side of body, including one arm and one leg

78 Three or more major parts of the body *(arms and legs)*

OTHER IMPAIRMENTS

80 Heart disease with no restriction or limitation of activity *(History of heart problems with complete recovery)*

81 Heart disease with restriction or limitation of activity

82 Convulsive disorder *(e.g., epilepsy)*

83 Blood diseases *(e.g., sickle cell anemia, leukemia, hemophilia)*

84 Diabetes

86 Pulmonary or respiratory disorders *(e.g., tuberculosis, emphysema asthma)*

87 Kidney dysfunctioning *(e.g., if dialysis [Use of an artificial kidney machine] is required)*

88 Cancer–a history of cancer with complete recovery

89 Cancer–undergoing surgical and/or medical treatment

90 Mental retardation *(A chronic and lifelong condition involving a limited ability to learn, to be educated, and to be trained for useful productive employment as certified by a State Vocational Rehabilitation agency under section 213.3102(t) of Schedule A)*

91 Mental or emotional illness *(A history of treatment for mental or emotional problems)*

92 Severe distortion of limbs and/or spine *(e.g., dwarfism, kyphosis [severe distortion of back])*

93 Disfigurement of face, hands, or feet *(e.g., distortion of features on skin, such as those caused by burns, gunshot injuries, and birth defects [gross facial birthmarks, club feet, etc.])*

94 Learning disability *(A disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts [spoken or written]; e.g., dyslexia)*

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Standard Form 256 (Rev. 8/87)
U.S. Office of Personnel Management
FPM Supplement 296-

The Rehabilitation Act of 1973 (P.L. 93-112) requires each agency in the Executive branch of the Federal Government to establish definite programs that will facilitate the hiring, placement, and advancement of handicapped individuals. The best means of determining agency progress in this respect is through the production of reports at certain intervals showing such things as the number of handicapped employees hired, promoted, trained, or reassigned over a given time period; the percentage of handicapped employees in the work force and in various grades and occupations; etc. Such reports bring to the attention of agency top management, the Office of Personnel Management (OPM), and the Congress deficiencies within specific agencies or the Federal Government as a whole in the hiring, placement, and advancement of handicapped individuals and, therefore, are the essential first step in improving these conditions and consequently meeting the requirements of the Rehabilitation Act.

The handicap data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept in the strictest confidence and is known only to the one or two individuals in the agency Personnel Office who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the handicap reporting system is entirely voluntary, **with the exception of employees appointed under Schedule A, section 213.3102(t) (Mental Retardation); Schedule A, section 213.3102(u) (Severely Physically Handicapped); and Schedule B, section 213.3202(k) (Mentally Restored).** These employees will be requested to identify their handicap status and if they decline to do so, their correct handicap code will be obtained from medical documentation used to support their appointment. No other employees will be required to identify their handicap status if they feel for any reason it is not in their best interest to have this information officially recorded outside of medical records. We request only that anyone not wishing to have this information entered in the agency's and OPM's personnel systems indicate this to their Personnel Office, rather than intentionally miscoding themselves, since false responses will seriously damage the statistical value of the reporting system.

[In those instances where the employee is or was hired under Schedule A, section 213.3102(t) (Mental Retardation), the Personnel Director or his/her disignee (a Vocational Rehabilitation Counselor may also be helpful) **will assist the individual in completing this form and ensure that the employee fully understands the meaning of the form and the options available to him/her, as noted above.]**

Employees will be given every opportunity to ensure that the handicap code carried in their agency's and OPM's personnel systems is accurate and is kept current. They may exercise this opportunity by asking their Personnel Officer to see a printout of the code and definition from their record, by notifying Personnel any time their handicap status changes, and by initiating action in either of these cases to have the necessary changes made to their records. The code carried on employees in their agency's system will be identical to that carried in OPM's system, and any change to the agency records will result in the same change being made to OPM's records.

PRIVACY ACT STATEMENT

Collection of the requested information is authorized by the Rehabilitation Act of 1973 (P.L. 93-112). The information you furnish will be used for the purpose of producing statistical reports to show agency progress in hiring, placement, and advancement of handicapped individuals and to locate individuals for voluntary participation in surveys. The reports will be used to inform agency top management, the Office of Personnel Management (OPM), the Congress, and the public of the status of programs for employment of the handicapped. All such reports will be in the form of aggregate totals and will not identify you in any way as an individual.

Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which requires agencies to use the SSN as the means for identifying individuals in personnel information systems. Your SSN will only be used to ensure that your correct handicap code is recorded along with the other employee information that your agency and OPM maintain on you. Furnishing your SSN or any other of the requested data for this collection effort is voluntary and failure to do so will have no effect on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data.

Employees appointed under Schedule A, section 213.3102(t) (Mental Retardation), Schedule A, section 213.3102(u) (Severely Physically Handicapped), or Schedule B, section 213.3202(k) (Mentally Restored) are requested to furnish an accurate handicap code, but failure to do so will have no effect on them. Where employees hired under one of these appointments fail to disclose their handicap, however, the appropriate code will be determined from the employee's existing records or medical documentation submitted to justify the appointment.

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